CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPLETED	
		155266	B. WING			12/20/2011	
	D OX WID DID OF				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				SPY RUN AVENUE		
	RE CENTER OF FO	RT WAYNE			WAYNE, IN46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000					Ti Di to ti ili		
		r the Investigation of	F0	000	This Plan of Correction is the		
	Complaint IN00100851.				Center's credible allegation of compliance.Preparation and/or		
	•	100851 - Substantiated.			execution of this plan of correction does not constitute		
		ficiencies related to the			admission or agreement by t		
		ed at F223, F225, and			provider of the truth of the fa- alleged or conclusions set fo		
	F226.				the state of deficiencies. The		
	Survey date: December 20, 2011				of correction is prepared and		
					executed because the provis of federal and state law requ		
	Facility number: 000167						
	Provider number: 155266						
	AIM number: 100273740						
	7 tiivi namber. 10	J0273740					
	Survey team:						
	Rick Blain, RN T	ГC					
	Sue Brooker, RD						
	Angela Strass, R						
	<i>8</i> :,						
	Census bed type:						
	SNF/NF: 77						
	Total: 77						
	Census payor typ	oe:					
	Medicare: 10	· - ·					
	Medicaid: 58						
	Other: 9						
	Total: 77						
	10tai: //						
	Sample: 3						
	These deficiencie	es reflect state findings					
LABORATOR	V DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG		-	TITLE	-	(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DVQN11

Facility ID:

000167

If continuation sheet

FORM APPROVED OMB NO. 0938-0391

PRINTED:

01/17/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155266 12/20/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE cited in accordance with 410 IAC 16.2. Quality review 12/22/11 by Suzanne Williams, RN The resident has the right to be free from F0223 verbal, sexual, physical, and mental abuse, SS=D corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. F 223 Free from F0223 01/19/2012 Based on record review and interview, the abuse/involuntary seclusion facility failed to ensure 1 of 3 residents 1.What corrective action(s) reviewed for abuse, in a sample of 3 will be accomplished for those residents, was free from physical abuse residents found to have been (Resident #B). affected by the deficient practice?The entire staff has been retrained as of 12/12/2011 Findings include: by the Staff Development Coordinator on the Abuse The record for Resident #B was reviewed Policy, signs of abuse, and the on 12/20/11 at 10:45 A.M. Diagnoses reporting of abuse. Every instance of suspected abuse of included, but were not limited to, any kind will be treated dementia. appropriately using the Abuse Policy and State guidelines. A facility incident investigation dated Any team member suspected 12/6/11, indicated on 11/19/11 at 10:10 of violating the Abuse policy will immediately be suspended P.M., Nurse pending investigation to #1 and CNA #2 responded to Resident ensure the safety of all #B calling out from her room and residents. observed CNA 2. How other residents having #3 on top of the resident, holding her the potential to be affected by the same deficient practice will be down in her bed. identified and what corrective actions will be taken. All alert and The facility Director of Nursing (DoN) oriented residents were

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED	
		155266	B. WIN			12/20/2	011	
			1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹		1649 SF	PY RUN AVENUE			
	RE CENTER OF FO	DRT WAYNE		FORT V	VAYNE, IN46805			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	was interviewed on 12/20/11 at 2:45 P.M.		-	TAG	interviewed by someone on t	·ho	DATE	
					leadership team. For those	ii i c		
	_	view, the DoN indicated			residents who are not alert a	nd		
		nd CNA #2 had witnessed			oriented, their representative	s		
		olving Resident #B and			were interviewed.: Monthly			
		9/11 at 10:10 P.M., and			reviews of the Abuse policy v			
	1	of the incident had			be conducted during the all s meeting the first payday Tue			
	substantiated the report of the incident.				of each month for a year by the Executive Director or her			
	The facility's nu	rse consultant was			designee. The Staff Develop	ment		
	interviewed on 12/20/11 at 2:50 P.M. During the interview, the nurse consultant indicated CNA #3 had not been				3.Systems to ensure allege	ed		
					deficient practice does not			
					recurCoordinator or her design will train new hires on the Ab			
	suspended immediately following the				policy during orientation. The			
	_	ncident had not been			Executive Director or her	,		
		1/6/11. The nurse			designee will manage suspected			
	consultant furthe			abuse allegations immediately				
				following state and facility				
	_	d substantiated the			policies.: Abuse reporting and follow up actions will be added to			
		e, and CNA #3 had been			monthly Process Improveme			
		2/7/11. The nurse			meeting to monitor for trends			
		ndicated CNA #3 had			completeness for the next ye			
	<u> </u>	ed in-servicing on the			 4.Monitoring to ensure alle deficient practice does not re 			
		policies prior to the			January 19, 2012	cui.		
	incident.				5.Date of Completion The resident was reassessed	d on		
	CNA #2 was into	erviewed on 12/20/11 at			12/6/2011 by the ADON and			
		ng the interview, she			found to have no negative			
		d witnessed the incident			outcomes. The staff member			
		ent #B and CNA #3 on			involved has been terminated	a.		
	_	ndicated she and Nurse #1						
		•						
		, , , , , , , , , , , , , , , , , , ,						
	_							
	heard Resident # room and they w observed CNA #	EB calling out from her vent to her room and £3 on the resident's bed, n. CNA #2 indicated						
	Nurse #1 told Ci	NA #3 to get off of the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155266		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2011	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE CENTER OF FO	ORT WAYNE		SPY RUN AVENUE WAYNE, IN46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	resident and she CNA #3 had told to prevent Resident into other resident On 12/20/11 at 1 Executive Direct policy entitled "A Reporting and R the policy was creatility. The polymust not be subjunyone"	did. CNA #2 indicated Nurse #1 she was trying ent #B from wandering		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE .

· ·		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	A. BUILDING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2011
		133200	B. WING		12/20/2011
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE O SPY RUN AVENUE	
LIFE CAF	RE CENTER OF FO	RT WAYNE		RT WAYNE, IN46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been found gor mistreating residuate had a finding nurse aide registry mistreatment of reof their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriatireported immediate	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State of concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an avould indicate unfitness for aide or other facility staff to de registry or licensing an insure that all alleged guistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance			
	with State law thro (including to the Stagency). The facility must halleged violations and must prevent the investigation is	ave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the addrepresentative and accordance with S State survey and c working days of the violation is verified action must be tak Based on record facility failed to be reported an allegathe Executive Direction actions.	review and interview, the ensure staff immediately ation of physical abuse to	F0225	F 225 Investigate/report allegations/individuals 1.What corrective action(s) wil accomplished for those residen found to have been affected by deficient practice? 2.How other residents having	ts the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155266	B. WIN			12/20/20	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			PY RUN AVENUE		
LIFE CAI	LIFE CARE CENTER OF FORT WAYNE				VAYNE, IN46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	failed to immediately			potential to be affected by the sa deficient practice will be identifie		
	protect residents	from further potential			and what corrective actions will I		
	abuse, for 1 of 3	residents reviewed for			taken.		
	abuse in a sampl	e of 3 residents (Resident			3.Systems to ensure alleged		
	#B).				deficient practice does not recur 4.Monitoring to ensure alleged		
					deficient practice does not recur		
	Findings include	•			5.Date of Completion		
	Tilldings illerade				: January 19, 2012: Abuse repo	rting	
	The man of C. D	anidant #D area are in a d			and follow up actions will be added to monthly Process		
	The record for Resident #B was reviewed on 12/20/11 at 10:45 A.M. Diagnoses included, but were not limited to,				Improvement meeting to mo	_{nitor}	
					for trends and completeness		
					the next year.: Monthly revie		
	dementia.				the Abuse policy will be		
					conducted during all staff me	-	
	A facility incide	nt investigation dated			the first payday Tuesday of		
	_	ed on 11/19/11 at 10:10			month for a year by the Exec Director or her designee. Ne		
	P.M., Nurse	· · · · · · · · · · · · · · · · · · ·			hires will be trained on the A		
	· ·	responded to Resident			policy during orientation by the		
		om her room and			Staff Development Coordina		
		om her room and			her designee. The Executive	;	
	observed CNA				Director or her designee will		
	_	resident holding her			manage suspected abuse		
	down in her bed				allegations immediately follo state and facility policies. The	-	
	_	licated the incident was			entire staff has been retraine		
	not reported to the	he Executive Director			the Staff Development		
	until 12/6/11. T	he incident investigation			Coordinator on the Abuse Po	olicy,	
	indicated the sta	te agency was notified of			signs of abuse, and the repo	rting	
		electronic mail on			of abuse. This was complete		
	12/6/11.	-			12/12/2011. Every instance of		
					suspected abuse of any kind be treated appropriately usin		
	The facility Dire	ector of Nursing (DoN)			Abuse Policy and State	y ii ie	
	1	• , ,			guidelines. Any team member	er l	
	was interviewed on 12/20/11 at 2:40 P.M.				suspected of violating the Ab		
	1	view, the DoN indicated			policy will immediately be		
		nd CNA #2 had witnessed			suspended pending investiga	ation	
	the incident invo	olving Resident #B and			to ensure the safety of all	.	
	CNA #3 on 11/1	9/11 at 10:10 P.M. The			residents. Per the Abuse po	IICY,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155266	1	LDING	00	12/20/2	
		100200	B. WIN		DDDEGG CITY OT TO CODE	1212012	· · ·
NAME OF I	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE		
LIFE CA	RE CENTER OF FO	ORT WAYNE			VAYNE, IN46805		
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TAG	+	LSC IDENTIFYING INFORMATION)		TAG	the team members who faile	d to	DATE
	DoN indicated CNA			the team members who failed to report the alleged incident		u io	
	_	rted the incident, since			immediately were disciplined		
		so witnessed the incident,			according to company policy		
		ought the nurse was going			Elaine Rathsack, Director of	.4:	
	•	dent. The DoN indicated			Nursing and Tony Hill, Execu Director on 12/6/2011, perfor		
		report the incident until			the discipline.		
	12/6/11, when she reported the incident to the Executive Director in a hand written				•		
	letter. The DoN indicated Nurse #1 had						
	not explained why she had waited until						
	12/6/11 to report the incident and that						
		ice been terminated. The					
		icated CNA #2 had					
		n warning for not					
		ident and had been					
		it reporting possible					
		ely. The DoN also					
		[‡] 3 was terminated					
	-	vestigation of the					
	incident.						
	The facility's nur	rse consultant was					
	interviewed on 1	2/20/11 at 2:50 P.M.					
	During the interv	view, the nurse consultant					
	indicated CNA #	[‡] 3 had not been					
	suspended imme	diately following the					
	incident, as the i	ncident had not been					
	reported until 12	/6/11. The nurse					
	consultant furthe	er indicated the					
	investigation had	d substantiated the					
	incident as abuse	e and CNA #3 had been					
	terminated on 12	2/7/11. The nurse					
	consultant also in	ndicated CNA #3 had					
	routinely receive	ed in-servicing on the					

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) facility's abuse policies prior to the incident. The facility's interim Executive Director was interviewed on 12/20/11 at 3:00 P.M. During the interview, she indicated it was facility policy that any staff who witnessed possible abuse were to immediately inform the Executive Director or by phone, allegations of abuse were to be investigated immediately, and staff suspected of possible abuse were to be suspended during the investigation of the incident. CNA #2 was interviewed on 12/20/11 at 3:00 P.M. During the interview, she	· ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	ĺ	LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/20/2	ETED
LIFE CARE CENTER OF FORT WAYNE (X4) ID (X5) (X5) (X5) (X5) (X5) (X5) (X5) (X5)	NAME OF D	RUAIDER UD SHIDDI IED				DDRESS, CITY, STATE, ZIP CODE		
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Director of the incident, either in person or by phone, allegations of abuse were to be investigated immediately, and staff suspected of possible abuse were to be suspended during the investigation of the incident. CNA #2 was interviewed on 12/20/11 at 3:20 P.M. During the interview, she		_						
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incident. CNA #2 was interviewed on 12/20/11 at 3:20 P.M. During the interview, she								
CNA #2 was interviewed on 12/20/11 at 3:20 P.M. During the interview, she			5 are my estigation of the					
3:20 P.M. During the interview, she								
3:20 P.M. During the interview, she		CNA #2 was inte	erviewed on 12/20/11 at					
indicated she had witnessed the incident		indicated she had	d witnessed the incident					
involving Resident #B and CNA #3 on		•						
11/19/11. She indicated she and Nurse #1								
heard Resident #B calling out from her			•					
room and they went to her room and		_						
observed CNA #3 on the resident's bed,								
holding her down. CNA #2 indicated		_						
Nurse #1 told CNA #3 to get off of the			_					
resident, and she did. CNA #2 indicated		· ·						
CNA #3 had told Nurse #1 she was trying to prevent Resident #B from wandering								
into other residents' rooms. During the		-	_					
interview, CNA #2 indicated she had not			_					
informed the Executive Director of the		,						
incident as Nurse #1 had also witnessed								
the incident, and she thought the nurse								

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(x2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155266		B. WING			12/20/2011	
NAME OF T	ADOLUDED OF CURRY TO				DDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER			1649 SPY RUN AVENUE				
LIFE CARE CENTER OF FORT WAYNE				1	VAYNE, IN46805			
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1710		Executive Director.		1710			DATE	
	was to illionii tiid	E EXECUTIVE DIRECTOR.						
	On 12/20/11 at 1	1:15 A.M., the interim						
	Executive Direct	or provided an undated						
	policy entitled "A	Abuse Investigation						
	Reporting and Re	esponse" and indicated						
	the policy was cu	irrently being used by the						
	facility. The pol	icy indicated "all alleged						
	violation of Fede	eral or State laws which						
	involve mistreatr	nent, neglect, abuse are						
	reported immediately to the Executive							
	Director of the facility." The policy							
	further indicated "the facility will							
	investigate each	such alleged violation						
	thoroughly" T	The policy also indicated						
	"If the suspected	perpetrator is an						
	associate, the Ex	ecutive Director shall						
	place the associa	te on immediate						
	investigatory sus	pension while						
	completing the ir	rvestigation."						
	This Federal tag	relates to Complaint						
	IN00100851.							
	3.1-28(c)							
	3.1-28(d)							
	3.1-28(e)							
F0226	The facility must d	evelop and implement						
SS=D		d procedures that prohibit						
30 ·D	mistreatment, neg	lect, and abuse of residents						
		ion of resident property.			F 000 Davidan/			
		review and interview, the	F	0226	F 226 Develop/implement abuse/neglect, etc. policies		01/19/2012	
	facility failed to	ensure implementation of			1.What corrective action(s) will	be		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	DVQN1	1 Facility I	D: 000167 If continuation s	heet Pa	ge 9 of 13	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 155266 12/20/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the facility's abuse policy regarding staff accomplished for those residents found to have been affected by the immediately reporting possible physical deficient practice? abuse to the Executive Director, 2. How other residents having the potential to be affected by the same immediately investigating possible deficient practice will be identified physical abuse, and protecting residents and what corrective actions will be from further potential abuse by 3.Systems to ensure alleged immediately suspending the involved deficient practice does not recur staff, for 1 of 3 residents reviewed for 4.Monitoring to ensure alleged deficient practice does not recur abuse in a sample of 3 residents (Resident 5.Date of Completion #B). : January 19, 2012: Abuse reporting and follow up actions will be added to monthly Process Findings include: Improvement meeting to monitor for trends and completeness for The record for Resident #B was reviewed the next year.: Monthly reviews of the Abuse policy will be on 12/20/11 at 10:45 A.M. Diagnoses conducted during all staff meeting included, but were not limited to, the first payday Tuesday of each dementia. month for a year by the Executive Director or her designee. New hires will be trained on the Abuse A facility incident investigation dated policy during orientation by the 12/6/11, indicated on 11/19/11 at 10:10 Staff Development Coordinator or P.M., Nurse her designee. The Executive #1 and CNA #2 responded to Resident Director or her designee will manage suspected abuse #B calling out from her room and allegations immediately following observed CNA state and facility policies. The #3 on top of the resident holding her entire staff has been retrained by down in her bed. The incident the Staff Development Coordinator on the Abuse Policy, investigation indicated the incident was signs of abuse, and the reporting not reported to the Executive Director of abuse. This was completed by until 12/6/11. The incident investigation 12/12/2011. Every instance of indicated the state agency was notified of suspected abuse of any kind will be treated appropriately using the the incident via electronic mail on Abuse Policy and State 12/6/11. guidelines. Any team member suspected of violating the Abuse The facility Director of Nursing (DoN) policy will immediately be

Facility ID:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/20/2	ETED
NAME OF 1	PROVIDER OR SUPPLIER	<u> </u>		DDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF FO	ORT WAYNE		PY RUN AVENUE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
TAG	was interviewed During the interviewed both Nurse #1 are the incident invo CNA #3 on 11/1 DoN indicated C #2 had not report Nurse #1 had als and the CNA the to report the inci Nurse #1 did not 12/6/11, when she the Executive Di letter. The DoN not explained when 12/6/11 to report Nurse #1 had sin DoN further indicated a writter reporting the incident indicated CNA # following the invincident. The facility's nurindicated CNA # suspended immediate indicated C	on 12/20/11 at 2:40 P.M. view, the DoN indicated and CNA #2 had witnessed alving Resident #B and 9/11 at 10:10 P.M. The ENA reted the incident, since to witnessed the incident, ought the nurse was going dent. The DoN indicated a report the incident until the reported the incident to rector in a hand written indicated Nurse #1 had my she had waited until the incident and that the been terminated. The ceated CNA #2 had in warning for not ident and had been at reporting possible by. The DoN also 43 was terminated vestigation of the rese consultant was 2/20/11 at 2:50 P.M. view, the nurse consultant 43 had not been diately following the incident had not been diately following t	TAG	suspended pending investigate to ensure the safety of all residents. Per the Abuse pothe team members who faile report the alleged incident immediately were disciplined according to company policy discipline was performed by Elaine Rathsack, Director of Nursing and Tony Hill, Exect Director on 12/6/2011.	licy, d to . The	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155266	B. WIN			12/20/20	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF FO	ORT WAYNE			PY RUN AVENUE VAYNE, IN46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	·		TAG	DEFICIENCT)		DATE
		d substantiated the e and CNA #3 had been					
		2/7/11. The nurse					
		ndicated CNA #3 had					
		ed in-servicing on the					
	I -	policies prior to the					
	incident.	onered prior to the					
	The facility's int	erim Executive Director					
	was interviewed on 12/20/11 at 3:00 P.M.						
	During the interview, she indicated it was						
	facility policy th						
	witnessed possib	ble abuse were to					
	immediately info	orm the Executive					
	Director of the in	ncident, either in person					
	or by phone, alle	egations of abuse were to					
	be investigated i	mmediately, and staff					
	suspected of pos	sible abuse were to be					
	suspended durin	g the investigation of the					
	incident.						
		erviewed on 12/20/11 at					
		ng the interview, she					
		d witnessed the incident					
		ent #B and CNA #3 on					
		ndicated she and Nurse #1					
		B calling out from her					
	_	vent to her room and					
		f3 on the resident's bed,					
	_	n. CNA #2 indicated					
		NA #3 to get off of the					
	1	e did. CNA #2 indicated					
		d Nurse #1 she was trying					
	to prevent Resid	ent #B from wandering					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		NSTRUCTION 00	(X3) DATE S COMPL		
		155266	A. BUII B. WIN	LDING G		12/20/2	
NAME OF E	PROVIDER OR SUPPLIER		B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
					PY RUN AVENUE		
	RE CENTER OF FC		_	<u> </u>	VAYNE, IN46805		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	into other resider	nts' rooms. During the					
	interview, CNA	#2 indicated she had not					
		ecutive Director of the					
		e #1 had also witnessed					
	· ·	she thought the nurse					
	was to inform the	e Executive Director.					
	On 12/20/11 at 1	1:15 A.M., the interim					
		or provided an undated					
		Abuse Investigation					
	Reporting and Response" and indicated						
	the policy was currently being used by the						
		icy indicated "all alleged					
		eral or State laws which					
		nent, neglect, abuse are					
	•	ately to the Executive					
	further indicated	"the facility will					
		such alleged violation					
	_	The policy also indicated					
		perpetrator is an					
	associate, the Ex	ecutive Director shall					
	place the associa	te on immediate					
	investigatory sus	*					
	completing the in	nvestigation."					
	This Endoral to a	relates to Complaint					
	IN00100851.	relates to Complaint					
	11.00100001.						
	3.1-28(a)						
	. ,						